

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
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Fax (802) 871-3318

May 6, 2013

Mr. Paul Bengtson, Administrator
Northeastern Vermont Regional Hospital
1315 Hospital Drive
Saint Johnsbury, VT 05819

Dear Mr. Bengtson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 27, 2013**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Division of
APR 17 13
Licensing and
Protection
PRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2013
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NAME OF PROVIDER OR SUPPLIER NORTHEASTERN VERMONT REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1315 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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C 000	INITIAL COMMENTS	C 000		
C 222	<p>485.623(b)(1) MAINTENANCE</p> <p>The CAH has housekeeping and preventive maintenance programs to ensure that--</p> <p>all essential mechanical, electrical, and patient care equipment is maintained in safe operating condition;</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that all patient care equipment was maintained in safe operating condition. Findings include:</p> <p>Per observation during the tour of the physical plant on 3/26/13 at 11:10 AM, portable gas tanks were improperly stored. Three "E" size oxygen and airgas portable tanks in a basement storage room were stored unsecured on the floor, creating a potential safety hazard. The Director of Plant Operations stated that the tanks should be stored in a rack or chained to a wall to prevent them from falling over and confirmed that the tanks were improperly stored at the time of the observation.</p>	C 222	<p>C222: 485.623(b) (1) MAINTENANCE</p> <p>The CAH has housekeeping and preventive maintenance programs to ensure that all essential mechanical, electrical, and patient care equipment is maintained in safe operating condition.</p> <p>Surveyors correctly reported that the standard was not met based on staff interview and observation of three "E" sized oxygen and airgas portable tanks in the basement storage area that were not secured in the storage rack.</p> <p>Corrective action was taken immediately and the tanks were individually placed in the appropriate storage rack with the chain secured to prevent them from falling. In addition to this, the vendor was contacted and instructed to only deliver the number of tanks that could be immediately placed for storage in the appropriate rack and secured according to policy with the safety chain in place. The Director of Plant operations communicated the requirements for proper storage of portable gas tanks to all members of the facilities department.</p> <p>The issue was corrected upon discovery while the surveyors were present in the facility.</p> <p>Richard DeGreenia, Director of Plant Operations, will monitor daily for compliance.</p>	3/26/13 <i>Colleen Smith VP Quality Improvement Borg</i>
C 278	<p>485.635(a)(3)(vi) PATIENT CARE POLICIES</p> <p>[The policies include the following:]</p> <p>a system for identifying, reporting, investigating</p>	C 278	<p>C278: 485.635((a)(3)(vi) PATIENT CARE POLICIES Response is on page 2 of 7</p>	<i>PDC B. Home / Feb 4.29.13</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul R. Byrne</i>	TITLE CEO	(X6) DATE 4/15/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 278	<p>Continued From page 1 and controlling infections and communicable diseases of patients and personnel.</p> <p>This STANDARD is not met as evidenced by: Based on on staff interview and record review, the hospital failed to ensure infection control measures were consistently implemented during the three bay sink sanitizing process in the kitchen; during cleaning of equipment in operating rooms and ensuring staff wore appropriate hair coverings during involvement with a surgical procedure. Findings include:</p> <ol style="list-style-type: none"> 1. During a tour of the kitchen on 3/25/13 at 11:15 AM, review of records for the three bay pot sink indicated that staff had not recorded sanitizer levels as required. Per interview with the Food Production Manager (FPM) on 3/26/13 at 9: 42 AM, sanitizer levels are to be checked whenever the water is changed, 3-5 times daily. Review of the sanitizer check lists showed that sanitizer levels had been checked sporadically in January and February 2013 and just twice in March 2013. These findings were confirmed by the FPM during the 3/26/13 9:42 AM interview. 2. During a tour of the perioperative area on 3/26/13 at 8:52 AM with the Nurse Manager for Surgical Services, in Operating Suite #1 the scrub nurse and circulating nurse were observed wearing PPE (hair coverings) that failed to completely cover their hair while actively involved in a surgical procedure. Per AORN (Association of periOperative Registered Nurses) Journal, January 2012 Vol 95 No 1 "Implementing AORN Recommended Practices for Surgical Attire, " states, "All personnel should cover their head 	C 278	<p><i>C278: 485.635((a)(3)(vi) PATIENT CARE POLICIES</i></p> <p><i>The policies include a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.</i></p> <p>Surveyors reported that the standard was not met in three areas based on direct observation and interview with staff:</p> <p>All three issues were corrected upon discovery while the surveyors were present in the facility.</p> <p><u>1. In the Kitchen a three bay pot sink sanitizing process was not consistently recorded.</u> The process for monitoring the sanitizer level with each water change in the three bay pot sink was included as a QA policy and communicated to all Food Service staff members. To ensure that the sanitizer is effective, pH is taken whenever a new tub of water is drawn. A new checklist was created with 4 slots to record pH for the four times each day the sink is filled. The early shift supervisor checks that the form is completed daily. Additionally, the early shift supervisor will do a random test at least once each week to verify the reading. The pot sink sanitizer is calculated to automatically add the sanitizer solution at a measured rate based on water flow which minimizes the potential of human error in the use of sanitizer at the three bay pot sink. This additional safety measure was not made clear during the survey interview.</p> <p>Virginia Flanders, Nutrition and Food Services Director, is responsible for monitoring the effectiveness of the process and implementing correction as well as process improvements when indicated.</p>

3/26/13
*Cheri Smith
 R.P. Quinlan
 J. Moore
 B. Brown*

*POC complete
 B. Flanders
 4.29.13*

per R. Byr CEO 4/15/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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C 278	<p>Continued From page 2</p> <p>and facial hair when in the semirestricted and restricted areas. Hair coverings should cover facial hair, sideburns, and the nape of the neck. Perioperative nurses can help minimize the risk of surgical site infections by covering head and facial hair...." AORN further states " Skull caps are not recommended because they do not completely cover the wearer's hair and skin; they fail to cover the side hair above and in front of the ears and the hair on the nape of the neck". The Nurse Manager confirmed at the time of observation, staff were not meeting standards of practice. Although the Nurse Manager confirmed the hospital had policies and procedures directing staff regarding proper surgical attire, the policy could not be provided for review at the time of survey.</p> <p>3. On 3/26/13 at 8:52 AM a staff member of Environmental Services was observed cleaning in OR #2. As the staff member cleaned per hospital policy "OR-Between Case Cleaning" effective date 04/05, the computer keyboard was not wiped down with disinfectant as the rest of the equipment surfaces had been cleaned. When asked if the computer keyboards were included in the process due to the multiple contacts made by staff during surgical procedures, the staff person acknowledged it was not a surface s/he was familiar with wiping down. Per interview on the morning of 3/27/13 the Director of Surgical Services confirmed the present hospital policy did not include the disinfecting of computer keyboards within the peri-Operative areas. Per American Journal of Infection Control, Vol 33, Issue 5, June 21, 2005, "Computer Equipment used in Patient Care within Multihospital System: Recommendations for cleaning and disinfection"</p>	C 278	<p><u>2. In the perioperative area the hair covering did not meet AORN recommended practices for surgical attire.</u> Perioperative staff members immediately placed the recommended head covering over their cloth coverings to become compliant with the Association of periOperative Registered Nurses article titled "Implementing AORN Recommended Practices for Surgical Attire." The departmental Surgical Attire policy was revised to include the AORN recommendations. Policy revisions were communicated to all surgical staff. Compliance with the policy is a performance expectation for all surgical staff members.</p> <p>Peter Tomczyk, RN, Clinical Coordinator for Surgical Service, is responsible for monitoring compliance with established policy and procedure.</p> <p><u>3. Existing policy for OR - Between Case Cleaning did not include the computer keyboards.</u> Two policies were immediately revised to meet the recommendations contained in the American Journal Of Infection Control article titled "Computer Equipment used in Patient Care within Multihospital System: Recommendations for cleaning and disinfection." NVRH Environmental Services Policy titled "OR-Between Case Cleaning" now includes a specific instruction to wipe down the computer keyboards using the same disinfectant and dwell times as indicated for all other items in the OR suite. The NVRH "OR-A.M. Wipe Down of Horizontal Surfaces" Policy now includes a statement instructing the specific wipe down of the computer keyboards. The policy change was communicated to all EVS staff members.</p> <p>(continued on page 4 of 7)</p>	<p>3/26/13</p> <p><i>Call Sme VP VP B...</i></p> <p>3/27/13</p> <p><i>Call Sme VP VP B...</i></p> <p><i>RC 4. 25.13 B...</i></p>

Peer Bay CEO 4/15/13

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C 278	Continued From page 3 states: When cleaning/disinfecting computer hardware, use the same type of cleaner/disinfectant and the same frequency of cleaning as would normally be used for other devices in that area. 2) The use of plastic keyboard covers or immerseable keyboards should be considered for direct patient care areas. 3. To ensure hand washing is included when handling computer equipment.	C 278	<u>3.(Cont.) Existing policy for OR - Between Case Cleaning did not include the computer keyboards.</u> All NVRH staff are required to follow the Hand Hygiene policy which requires hand washing prior to putting on gloves and after removing the gloves. As part of the current QI project, we will begin surface monitoring using the ATP monitoring device. Pamela Applebee, CHESP, Environmental Services Manager will be responsible for monitoring compliance with established policies.	
C 302	485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on interview and record review, a History and Physical document was found to be written inaccurately for 1 of 21 applicable patients (Patient #6). Findings include: Per review on 3/26/13, a History and Physical Examination was completed and dictated on 3/18/13 by a Physician Assistant (PA) for Patient #6, admitted to the hospital for a left hip arthroplasty. The PA initially accurately describes the gender for Patient #6 to be male. However, later within the document Patient #6's gender is then described as a female and weighing 136 pounds and whose height is 5 ft 5 inches. The nursing assessment correctly noted Patient #6's admission weight to be 260 pounds and height was measured at 5 ft 8 inches. In addition, the surgeon who performed the surgical procedure had signed the History and Physical document without correcting the identified errors. The inaccurate record was confirmed during interview with the Medical/Surgical Nurse Manager on	C 302	C302 485.638(a)(2) RECORDS SYSTEM <i>The records are legible, complete, accurately documented, readily accessible, and systematically organized.</i> Surveyors reported that based on staff interview and record review one History and Physical Examination was found to be written inaccurately. History and Physical exams are dictated by the provider and transcribed by professional transcriptionists in the Medical Records Department. The transcriptionist used a "normal" which is a template made up of the sections and order used routinely by the dictator(s). The documentation for a female patient contained in the second History and Physical section displayed on the document was a transcription error. The original audio record of the dictation was retrieved and the provider dictated the appropriate information for the male patient. The template used by the transcriptionist contained the section from a previous female patient dictated by this provider. The findings related to this error were communicated to the provider and the Medical Records staff. <i>(continued on page 5 of 7)</i>	4/15/13 <i>Call on VP during PIP</i> <i>POC completed B. Hume/SL 4-25-13</i>

Per R By CEO 4/15/13

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C 302 C 303	Continued From page 4 3/26/13 at 10:30 AM. 485.638(a)(3) RECORDS SYSTEMS A designated member of the professional staff is responsible for maintaining the records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on interview and record review the present medical record systems are not unified and organizationally structured to be readily accessible and systematically organized. Findings include: 1. Per review the medical record for Patient #1, who had been discharged on 12/24/12, was requested by the surveyor on 3/26/13, was not accessible for review until the afternoon of 3/27/13. During interview at the time of record review the RN Unit Manager stated that the BC (Birthing Center) adopted a new EMR (electronic medical record) system in February of 2012. S/he stated that the medical records of patients on the BC are accessible, electronically, to staff for a period of 90 days post discharge at which time the record is archived onto a CD. The Unit Manager stated copies of each individual patient's CD are then physically stored only in the BC and with a specifically identified staff member in IT (information technology), and are accessible only through request to either the BC Unit Manager or the specified IT staff member. S/he stated the archived medical record (CD) is not stored in the Medical Records Department and the Director of Medical Records has no oversight of the archived records.	C 302 C 303	(continued from page 4 of 7) C302 485.638(a)(2) RECORDS SYSTEM The records are legible, complete, accurately documented, readily accessible, and systematically organized. Transcriptionists were reminded to pay close attention the "normal" templates and proof read carefully before signing off the dictation. The provider was also reminded that ultimately it is the provider's responsibility to read each note carefully before signing the document. Susan Merrow, RHIT, CPC, Manager Medical Records is responsible for monitoring for ongoing compliance. C303 485.638(a)(3) RECORDS SYSTEM A designated member of the professional staff is responsible for maintaining the record and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized. Based staff interviews and observation, the surveyors reported that the medical records systems were not unified and organizationally structured to be readily accessible and systematically organized. NVRH maintains the content of our records either in paper or electronic format. Meditech 6.0 is our main storage system for the electronic medical record (EMR). Hospital owned Physician Office Practice records (EMR) are maintained on the LSS Meditech system. The Meditech system did not meet the needs of our Birthing Service and a specialized Obstetric system, GE Centricity, was purchased one year ago to meet the documentation and patient safety needs of the population served by the Birth Center. The management of this system and the Birthing Records became the responsibility of the Director of Birthing Services and one assigned staff member from Information Services. (continued on page 6 of 7)	4/15/13 Cau Sam VP Surgery Morgan Higano BC audit 4.29.13 S. Home

Per BY CEO 4/15/13

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C 303	Continued From page 5	C 303	C303 485.638(a)(3) RECORDS SYSTEM <i>(continued from page 5 of 7)</i> All requests for patient records, including requests from the Medical Records Department, were provided by these individuals. In response to survey findings, immediate corrective action was taken to assure that all electronic records were unified and organizationally structured under the responsibility of the Manager of Medical Records.	
C 307	485.638(a)(4)(iv) RECORDS SYSTEMS [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-] dated signatures of the doctor of medicine or osteopathy or other health care professional. This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview the facility failed to assure that all medical record entries were dated, timed and authenticated for 1 of 21 applicable records reviewed. (Patient #8). Findings include: Per review Patient #8, who underwent a surgical procedure on 2/12/13 requiring administration of general anesthesia, had an intraoperative anesthesia monitoring record that lacked the date, time and signature of the person who completed the form. This was confirmed by the VP of Quality Management Programs during interview on the morning of 3/27/13.	C 307	The Manager of Medical Records received GE Centricity training for use and retrieval of archived records. Centricity creates a CD every 120 days of records that are archived and would need to be restored if a document was requested. There will now be three copies of the CD. One copy will remain in Medical Records for easy retrieval of requested information. The other two copies will continue to be stored with the Manager of Birthing Services and one stored off site with IS. The Policy and Procedure for Accessibility of Patient's Medical Records was revised to support the change in practice. Susan Merrow, RHIT, CPC, Manager of Medical Records is responsible for ongoing process improvement activity, education of staff members and monitoring for compliance with the established policy and procedure.	
C 322	485.639(b) ANESTHETIC RISK & EVALUATION (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the	C 322	C307 485.638(a)(4)(iv) RECORDS SYSTEM <i>For each patient receiving health care services, the CAH maintains a record that includes, as applicable— dated signatures of the doctor of medicine or osteopathy or other health care professional.</i> One record was not in compliance. The anesthesia Department will add a review of the Intraoperative Anesthesia Monitoring Record documentation to the current Monthly QA activity beginning with April 2013 records. Findings will be submitted monthly to the Surgery Committee. Dr. Stephen Fischer, Director of Anesthesia Services, is responsible for ongoing monitoring, improvement activity and compliance with the regulatory requirements for documentation.	4/15/13 <i>Call Stephen Fischer 4/29/13 D. Howe/SLP</i>

Per R By

CEO 4/15/13

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C 322	Continued From page 6 risk of the procedure to be performed. (2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia. (3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to assure an anesthesia evaluation to determine proper recovery from anesthesia was conducted prior to discharge for 1 applicable patient. (Patient #8). Findings include: Per review the record for Patient #8, who underwent a surgical procedure requiring the use of general anesthesia on 2/12/13, did not contain evidence of a post anesthesia evaluation, conducted to determine the patient's recovery from anesthesia. The Manager for Peri-Operative Services confirmed the lack of a post - anesthesia evaluation during interview at 1:10 PM on 3/27/13.	C 322	<i>C322 485.639(b) ANESTHETIC RISK & EVALUATION</i> <i>(1) A qualified practitioner as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed. (2) A qualified practitioner as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia. (3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.</i> One record was not in compliance with the standard as reported by the surveyors. The anesthesia Department will add a review of the post anesthesia evaluation documentation to the current Monthly QA activity beginning with April 2013 records. Findings will be submitted monthly to the Surgery Committee. Dr. Stephen Fischer, Director of Anesthesia Services, is responsible for ongoing monitoring, improvement activity and compliance with the regulatory requirements for documentation.	4/15/13 <i>See Site Report Surgery Report</i>	

*Revised
D. Bone / ed
4.25.13*

Per R By CEO 4/15/13

NVRH Nutrition and Food Service

Quality Assurance for Pot Sink Sanitizer

To ensure that the sanitizer is effective, pH is be taken whenever a new tub of water is drawn. There is a new chart with 4 slots to record pH for the 4 times the sink gets filled. The early shift supervisor checks that the form is completed daily. Additionally, the early shift supervisor will do a random test at least once a week to verify the reading.

The pot sink sanitizer is calculated to add the sanitizer solution at a measured rate based on water flow. This minimizes the potential of human error in the use of sanitizer at this sink.

4-25-13
G. P. [unclear]
[unclear]

Checklist to Sanitize in Pot Sink

Dip the strip in the water. Hold hand still and count to 10.

Pull out strip, match it with the color coded area on the pHydriion paper QT-40.

Record results below. REPORT ANY RESULTS NOT IN RANGE TO SUPERVISOR

Date	Time/initial	Reading	Time/initial	Reading	Time/initial	Reading	Time/initial	Reading
3/26/13								
3/27								
3/28								
3/29								
3/30								
3/31								
4/1								
4/2								
4/3								
4/4								
4/5								
4/6								
4/7								
4/8								
4/9								
4/10								
4/11								
4/12								
4/13								
4/14								
4/15								
4/16								
4/17								

4-26-13
B. [Signature]

**Northeastern Vermont Regional Hospital
Perioperative Services/ Operation Room****Purpose**

To provide guidance to perioperative personnel for surgical attire, including jewelry, clothing, shoes, head coverings, masks, jackets, and other accessories worn in semirestricted and restricted areas. Surgical attire and appropriate personal protective equipment (PPE) are worn to promote worker safety and a high level of cleanliness and hygiene in the perioperative environment. The expected outcome is that the patient will be free from signs and symptoms of infection.

Policy

It is the policy of **NVRH Surgical Services** that:

- Clean surgical attire, including scrub suits, shoes, head coverings, masks, jackets, and identification badges, will be worn in semirestricted and restricted areas.
- All individuals who enter semirestricted and restricted areas will wear freshly laundered or single-use scrub attire provided by the facility and intended for use within perioperative areas.
- All personal clothing must be completely covered by surgical attire.
- All perioperative personnel will change into street clothes when leaving the facility or traveling between buildings located on separate campuses.
- Identification badges will be worn by all personnel authorized to enter perioperative areas.
- Shoes worn within the perioperative environment must
 - meet Occupational Safety and Health Administration (OSHA) standards for protective footwear;
 - be constructed to prevent exposures to blood, body fluids, and other potentially infectious materials (e.g., no holes or perforations); and
 - have closed toes and backs, low heels, and non-skid soles.

Procedure Interventions*Attire in Semirestricted and Restricted Areas*

- Don clean and freshly laundered or single-use scrub attire daily in the designated dressing area before entering semirestricted and restricted areas.
 - When donning, prevent clean surgical attire from contacting the floor or other contaminated surfaces.
 - Check that all personal clothing is completely covered by the surgical attire.
 - Tuck the top of the scrub suit into the pants if it does not fit close to the body.
 - Wear long-sleeved jackets with the snaps closed and with the cuffs down to the wrists.
 - Discard single-use scrub attire in a trash container or place reusable items in a designated laundry container.
 - Do not place reusable items in a locker for future use.
 - Scrub attire that has gotten wet or been penetrated by blood, body fluids, or other potentially infectious material must be removed as soon as possible and discarded (single-use) or placed in a designated laundry container (reusable).
 - Do not use fabric covers for stethoscopes.
- All perioperative personnel will cover head and facial hair, including sideburns and the nape of the neck.
- Non-perioperative personnel entering semirestricted or restricted areas of the facility for a brief time for a specific purpose (eg, law enforcement officers, parents, biomedical engineers) will cover all head and facial hair with a single-use head cover and don freshly laundered surgical attire or a single-use jumpsuit (eg, bunny suit).
- Shoes worn within the perioperative environment will be clean.

4-24-13
Bifford

Northeastern Vermont Regional Hospital Perioperative Services/ Operation Room

- Contain all jewelry, including earrings, necklaces, watches, and bracelets, within the surgical attire.
 - Remove watches and rings before hand washing or using hand rubs.
- Fanny packs, briefcases, and backpacks are not permitted in semirestricted or restricted areas of the perioperative suite.

Masks in Restricted Areas

- All individuals entering restricted areas will wear a mask when open sterile supplies and equipment are present.
 - Masks will cover the mouth and nose and be tied securely.
 - A fresh, clean surgical mask will be worn for every procedure.
 - Only one mask will be worn at a time.
 - Masks will be discarded whenever they become wet or soiled.
 - Masks will not be worn hanging down from the neck.
 - Hand hygiene will be performed after removal of masks.

Competency

All perioperative personnel working in semirestricted and restricted areas of the facility will receive education and complete competency validation activities on surgical attire worn in the perioperative environment, including:

- areas where surgical attire must be worn;
- infection prevention and control as they apply to surgical attire and the patient, the perioperative team member, the perioperative team member's family members, and the community where the perioperative team member resides;
- laundering requirements; and
- storage of clean and contaminated attire.

Glossary

Personal protective equipment (PPE): Specialized equipment or clothing for eyes, face, head, body, and extremities; protective clothing; respiratory devices; and protective shields and barriers designed to protect the worker from injury or exposure to a patient's blood, tissue, or body fluids. Used by health care workers and others whenever necessary to protect themselves from the hazards of processes or environments, chemical hazards, or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation, or physical contact.

Restricted area: Includes the OR and procedure room, clean core, and scrub areas. People in this area are required to wear full surgical attire and cover all head and facial hair, including sideburns, beards, and necklines.

Semirestricted area: Includes the peripheral support areas of the surgical suite and has storage areas for sterile and clean supplies, work areas for storage and processing instruments, and corridors leading to the restricted areas of the surgical suite.

Surgical attire: Non-sterile apparel designated for the perioperative practice setting that includes two-piece pantsuits, long-sleeved jackets, head coverings, shoes, masks, protective eyewear, and other protective barriers.

References

4.29.13
B. [unclear]
[unclear]

**Northeastern Vermont Regional Hospital
Perioperative Services/ Operation Room**

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 October 29, 2012.

Occupational Safety and Health Administration. 1910.1030: Bloodborne pathogens.
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Petersen C, ed. *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2010.

Recommended practices for surgical attire. In: *Perioperative Standards and Recommended Practices*.
 Denver, CO: AORN, Inc; 2013:51-62.

ADMINISTRATIVE APPROVAL

Date Created: _____

Last Date Revised: April 2013

Last Date Reviewed: November 2010

Date of Next Review: _____

Approval signature(s) with title and date of signature:

 Signature Director Perioperative Services Date

 Signature VP Professional Services Date

 Signature Chair, Surgical Committee Date

*Blair
 4.25.13
 B. M.*

Effective Date: 04/05

Review Dates:

Approvals:

Revision Date: 3/26/13

POLICY TITLE: OR- Between Case Cleaning**POLICY:**

- Environmental Service staff will thoroughly clean each OR Suite between each case beginning with the OR bed and moving in an outward direction, following the procedure below.
- Each step will be followed in the order presented to allow for appropriate dwell time of the chemical used, which is 2 minutes
- No spraying is allowed in the suites. Disinfectant will be applied to the cleaning cloth using a pour spout

PURPOSE:

- To ensure that all areas are clean, dry and safe for Physicians, staff and patients.
- To protect patients and staff against infection and other diseases

CLEANING SUPPLIES NEEDED

33 gal and 56 gal trash bags

red bags

clean cloths

Disinfectant-Clorox Broad Spectrum

scrubber/ wet mop

PROCEDURE:

1. **Put on gloves and any other PPE needed.**
2. Strip bed putting linen into laundry cart
3. Wet a fresh cleaning cloth in disinfectant leaving it wet enough to keep the bed wet for the entire 2 min dwell time needed as per chemical instructions. Start washing down the entire bed making sure to get under all cushions. Leave cushions up to air dry. **Note the time you finished wiping down the bed**
4. Wipe the lights and Mayo stand leaving them wet enough to get the entire 2 min dwell time needed as per chemical instructions.
5. Remove laundry and trash from room- set outside of room until room is cleaned
6. Working your way out from the bed, and clockwise around the room,
 - **Wipe down everything that remains in the suite**, including blood pressure cuffs and tubing and all horizontal surfaces including key boards.
 - Blood pressure cuffs and tubing are to be wiped down between eye cases as well and all horizontal surfaces
 - Check the room over- (Lights, cabinets, walls, doors and unused equipment) for blood or any soiling. Clean with disinfectant.
7. Move bed out of the way to clean the floor. Wash the 3-4 ft radius around the table, more if soiling is found further out. Move bed back into place and finish washing. **Check the time.**
Note: Virex or water may be used to rewipe after the 2 min dwell time
 - **If the OR was after terminal cleaning had been done by 2nd shift, the entire floor must be washed**
8. Once the room has been cleaned, remove gloves and remake bed as per request.

Clean linen needed:

- Flat sheet Draw sheet Clean laundry bag
- Pillow cases for pillow and arm rests

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B. Hunt

9. Take trash to the soiled utility room where you will then place the appropriate sticker for the OR suite you cleaned onto the bag. Place into the OR trash bin. Once it has been OK'd by OR staff that no instruments are missing, it may be remove to the trash bin outside the OR for disposal
10. Take linen to soiled utility room and place into the linen bin.
11. Replace trash liners and laundry bags

Effective Date: 04/05

Review Dates:

Approvals:

Revision Date: 9/5/11

TITLE: OR- A.M. Wipe Down of Horizontal Surfaces

POLICY:

- Upon arrival to the OR, Environmental Service staff will do a wipe down of all horizontal surfaces, surgical lights and do a recheck in OR Suites 1,2,3 and the Procedure room

PURPOSE:

- To remove dust particles that may have settled over night.
- To recheck rooms before surgeries begin
- To make sure all OR suites are closed off from scrub rooms and storage areas

Supplies needed

Clean cloths

Disinfectant

PROCEDURE:

- Using a damp cloth and working your way around each room, wipe all horizontal surfaces beginning with the lights. This will include any computer areas.
- Make sure all doors from the OR suites are closed- storage rooms and scrub rooms
- As you move around the room also keep an eye on the walls and floors for blood and other soil, clean as necessary

*Account
4-25-11
B. Rose / H*

Applebee, Pam

From: Applebee, Pam
Sent: Monday, April 15, 2013 8:31 AM
To: Sinon, Colleen
Subject: FW: OR Between Case Cleaning

*Colleen-I didn't know if you also needed the documentation on the communication of the revision but here it is
Pam*

From: Applebee, Pam
Sent: Tuesday, March 26, 2013 11:20 AM
To: Noyes, Elaine; Taylor, Donna; Griffin, Georgette; Simpson, Janet; Talbot, Anna; Dingman, Theresa; Robert, Michelle; Allen, Carol; Hooker, Teala; Mooney, Brian
Subject: OR Between Case Cleaning

*Here is a revised copy of the **OR Between Case Cleaning** policy/procedure Please replace what you have in your books. The revision adds wiping the keyboard down with a cloth dampened with Broad Spectrum after each case.*

*Virex should only be used on the floor after you have used the Broad Spectrum on the 3-4 ft around the table
And during terminal cleaning to get the whole floor*



OR Between Case
Cleaning.pdf

*PBC update
4/26/13
Sut / B 12x*

NORTHEASTERN VERMONT REGIONAL HOSPITAL
ST. JOHNSBURY, VERMONT

INFECTION CONTROL/EMPLOYEE HEALTH
POLICIES & PROCEDURES

SUBJECT: Hand Hygiene - Routine
APPROVED BY: Infection Control Committee
Effective: Nov. 1. 2002

DEPT./SCOPE: Hospital wide
DATE: Nov. 2002
Supersedes: Previous

POLICY STATEMENT: Hand washing and hand hygiene are the fundamental cornerstones of controlling the spread of infection. NVRH provides the facilities and products for effective hand washing and hand hygiene.

POLICY PURPOSE: To provide direction in proper hand washing and hand hygiene technique.

CONTENT: Hands must be washed thoroughly with soap and water when visibly soiled. Hands must be cared for by hand washing with soap and water or by hand antiseptics with alcohol-based hand rubs. Alcohol based hand rubs may only be used if there is not obvious soil or organic material present.

Hands hygiene must take place:

1. Before and after patient contact.
2. After contact with a source of microorganisms.
3. After removing gloves.
4. After performing any personal functions, such eating, drinking, applying cosmetics or using the rest room.
5. Whenever indicated to avoid transfer of microorganisms to patients, staff or the environment.

BASIC HAND WASHING TECHNIQUE:

1. Turn on the water and adjust the temperature. Warm water is acceptable.
2. Wet hands with running water.
3. Apply soap or selected hand washing agent., and distribute thoroughly over hands.
4. Vigorously rub hands together for 10 to 15 seconds, covering all surfaces of the hands and fingers, and around wrists. If hands are visibly soiled, more time may be required.
5. Rinse hands well under running water. Have hands pointing down during rinsing.
6. Obtain paper towels, and dry hands. Obtain additional paper towels to turn off faucets. Discard paper towels into waste container.

USE OF ALCOHOL-BASED HAND RUB:

If hands are not visibly soiled, you may use an alcohol-based hand rub for routinely decontaminating hands.

To use properly, dispense enough hand rub in your palm to thoroughly cover your hands. Rub hands together briskly until dry.

OTHER:

Rings and jewelry should be kept to a minimum. Nails should be kept short and well groomed. Do not wear artificial nails or extenders when having contact with high risk patients (ICU, OR, Nursery).

Hand lotion should be used often to maintain the skin's integrity.

RESPONSIBILITY: All departments, all employees.

*Reviewed
4/26/13
B. Howe/ed*

NORTHEASTERN VERMONT
REGIONAL HOSPITAL
ST. JOHNSBURY, VERMONT

INFECTION CONTROL/EMPLOYEE HEALTH
POLICIES & PROCEDURES

SUBJECT: Hand Hygiene - Routine

DEPT./SCOPE: Hospital wide

APPROVED BY: Infection Control Committee

DATE: Nov.2002

Effective: Nov. 1. 2002

Supersedes: Previous

POLICY STATEMENT: Hand washing and hand hygiene are the fundamental cornerstones of controlling the spread of infection. NVRH provides the facilities and products for effective hand washing and hand hygiene. Hand hygiene adherence is an institutional priority at NVRH, supported by administrative support and financial resources.

POLICY PURPOSE: To provide direction in proper hand washing and hand hygiene technique.

CONTENT:

SELECTION OF HAND HYGIENE PRODUCTS

1. Personnel will be supplied with efficacious hand hygiene products that have low irritancy potential. Fragrance free products will be supplied whenever possible.
2. Hand hygiene products will be reviewed by the Product Standards Committee before purchase.
Issue to be reviewed are product compatibility with gloves and other materials, evaluation of dispensing systems, package integrity to avoid contamination, and recommendations for use in the health care setting.
3. Front line employees will be included in product evaluation before a final decision is made.

HAND HYGIENE

All new employees will receive education on hand hygiene during their new employee orientation, and annually through the Healthstream annual mandatory education.

Hands must be washed thoroughly with soap and water when visibly soiled. Hands must be cared for by hand washing with soap and water or by hand antisepsis with alcohol-based hand rubs. Alcohol based hand rubs may only be used if there is not obvious soil or organic material present on either hands

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or gloves.

Hands hygiene must take place:

1. When hands are visibly dirty (see Basic Handwashing Technique and Use of Alcohol Hand Rub)
2. Before and after direct patient contact.
3. Before and after performing any invasive procedure
4. Before donning sterile gloves when inserting a central intravascular catheter
5. After contact with a source of microorganisms (inanimate objects including medical equipment in the immediate vicinity of the patient.
6. After removing gloves.
7. After contact with body fluids, excretion, mucous membranes, nonintact skin and wound dressings.
8. After contact with a patient's intact skin (e.g. when taking a pulse or blood pressure, lifting a patient, etc)
9. When moving hands from a contaminated body site to a clean body site during patient care.
10. After performing any personal functions, such eating, drinking, applying cosmetics or using the rest room.
11. Whenever indicated to avoid transfer of microorganisms to patients, staff or the environment.

BASIC HAND WASHING TECHNIQUE:

1. Turn on the water and adjust the temperature. Warm water is acceptable.
2. Wet hands with running water.
3. Apply the recommended amount of soap or selected hand washing agent and distribute thoroughly over hands.
4. Vigorously rub hands together for at least 15 seconds, covering all surfaces of the hands and fingers, and around wrists. If hands are visibly soiled, more time may be required.
5. Rinse hands well under running water. Have hands pointing down during rinsing.
6. Obtain paper towels, and dry hands. Obtain additional paper towels to turn off faucets. Discard paper towels into waste container.

Liquid, bar, leaflet or powdered forms of soap are acceptable when washing hands with non-antimicrobial soap and water. When bar soap is used, soap racks that facilitate drainage and small bars of soap are to be used.

Multiple-use cloth towels of the hanging or roll type are not to be used.

USE OF ALCOHOL-BASED HAND RUB:

If hands or gloves are not visibly soiled, you may use an alcohol-based hand rub for routinely decontaminating hands.

To use properly, dispense enough hand rub in your palm to thoroughly cover your hands. Rub hands together briskly until dry.

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Please Note:

Alcohol hand rubs are NOT effective against the spores of *C. difficile*. For those patients with known or suspect *C. difficile* infection, handwashing with soap and water is mandatory.

Antimicrobial-impregnated wipes (towelettes) may be considered as an alternative to washing hands with non-antimicrobial soap and water. Because they are not as effective as alcohol-based hand rubs or washing hands with an antimicrobial soap and water for reducing bacterial counts on hands, they are not a substitute for using an alcohol-based hand rub or antimicrobial soap.

SURGICAL HAND ANTISEPSIS

1. Remove rings, watches and bracelets before beginning the surgical hand scrub.
2. Remove debris from underneath fingernails using a nail cleaner under running water.
3. Surgical hand antiseptics using either an antimicrobial soap or alcohol-based hand rub with persistent activity is required before donning sterile gloves when performing surgical procedures.
4. When performing surgical hand antiseptics using an antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually 2-6 minutes.
5. When using an alcohol-based surgical hand scrub product with persistent activity, follow the manufacturer's instructions. Before applying the alcohol solution, pre-wash hands and forearms with a non-microbial soap and dry hands and forearms completely. After application of the alcohol-based product as recommended, allow hands and forearms to dry thoroughly before donning sterile gloves.

OTHER:

1. Rings and jewelry should be kept to a minimum. Rings, bracelets, watches, etc. are easily contaminated with organisms and are difficult to routinely clean throughout the workday. Jewelry then becomes a reservoir, and provides a mode of transmission from patient to patient and to the worker's home. Rings may remain on hands during the washing process, with special care taken for complete rinsing under the rings. Bracelets and watches should be removed and cleaned individually. Nails should be kept short and well groomed. Do not wear artificial nails or extenders when having contact with high risk patients (ICU, OR, Nursery).
2. Keep natural nail tips less than 1/4 inch long.
3. Wear gloves when contact with blood, body fluids, other potentially infectious materials, mucous membranes and non-intact skin could occur.
4. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients.
5. Change gloves during patient care if moving from a contaminated body site to a clean body site.

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SKIN CARE:

Hand lotion and creams are provided to minimize the occurrence of irritant contact dermatitis. Healthcare workers are advised to use these products often to maintain the skin's integrity.

HAND HYGIENE PROCESS IMPROVEMENT PROJECT

Improving healthcare personnel's compliance with hand hygiene is an institutional priority at NVRH. To help increase adherence of healthcare personnel to recommended hand-hygiene practices, Infection Control will provide a written policy describing recommendations of the CDC Guideline for

Hand Hygiene in Health Care Settings (Oct. 2002); present detailed information of the importance of hand hygiene during new employee orientation; include review of the hand hygiene policy / recommendations on-line through the Healthstream annual mandatories.

Infection Control will monitor hand hygiene compliance by the following methods:

A. Monitor the volume of alcohol-based hand rub used per 1000 patient days.

Action: Data compiled retrospectively for 2002 - 2010. Please see included report.

B. Periodically monitor and record adherence as the number of hand-hygiene episodes performed by personnel/number of hand hygiene opportunities by ward or by service, and provide feedback to personnel regarding their performance.

Action: For 2011, the Infection Control Coordinator will perform unannounced, random surveys of hand hygiene compliance during the months of June and December. Infection Control will also develop a plan to recruit auditors from other departments to assist in surveillance. Compliance results will be posted in individual departments, and reported to the Medicine Committee. The compliance results will guide improvement efforts.

C. Monitor the adherence to policies dealing with wearing of artificial nails.

Action: In accordance with the CDC / HICPAC Guidelines for Hand Hygiene in Health-Care Settings, the hand hygiene policy reads: "Do not wear artificial nails or extenders when having contact with high risk patients (ICU, OR, Nursery)". Compliance will be monitored by Department Managers.

D. When outbreaks of infection occur, assess the adequacy of health-care worker hand hygiene.

Action: Outbreaks of infection will be detected through the ongoing infection surveillance performed by Infection Control. When an outbreak or cluster of infection is recognized, review of hand hygiene practices

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will be conducted for the area or department involved as part of the epidemiological investigation, and corrective action taken as appropriate to the situation.

E. Patient and their families are encouraged to remind care givers to perform hand hygiene. Educational material "IT'S OKAY TO ASK" is distributed throughout the hospital.

RESPONSIBILITY: All departments, all employees.

REFERENCES / SUPPORTIVE DATA:

Guidelines for Hand Hygiene in Health-Care Settings, HICPAC, Oct. 25, 2002.

JCAHO IC.1

REVISED / REVIEWED:

Revised: Nov. 1, 2002
Reviewed: Dec. 11, 2003 DM
Reviewed: Dec. 9, 2004 DM
Reviewed: Dec. 8, 2005 DM
Revised: Dec. 7, 2006 DM
Reviewed: Dec. 6, 2007 DM
Reviewed: Dec. 7, 2008 DM
Revised: Dec. 4, 2009 DM
Reviewed: Dec. 3, 2010 DM
Revised: April 14, 2011 DM

4-25-11
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Sinon, Colleen

From: Merrow, Susan
Sent: Friday, April 12, 2013 4:18 PM
To: Cloutier, Kathleen; Brown, Margaret; Littel, Marcia; Chamberlin, Marilyn; Barrett, Holly; Thomas, Carol; Garrett, Christine
Cc: Sinon, Colleen
Subject: Transcription Error

Dear Staff,

When CMS was here in March they had some concerns regarding a portion of a medical record for a patient on the floor. In following up on the concerns we have discovered how the error occurred. The transcriptionist doing the note used a normal (template that is used routinely by dictator(s)) that she had created and left a portion of an entry that should have been erased in the report. The dictator did not dictate the entry made by the transcriptionist and referred to the patient as being male all through the report. I will be letting the provider know that the errors made were clerical and in no way was he responsible for what was transcribed, but ultimately it is the provider's responsibility to read the note carefully before signing but again, it is difficult proofing your own work as you know what was said etc.

So, moving forward I would encourage all transcriptionist to pay close attention to your normals and do as much proofing as you can before signing off a note.

Sue

Susan Merrow, RHIT, CPC
Manager Medical Records
Northeastern VT Regional Hospital
1315 Hospital Drive - PO Box 905
St. Johnsbury, VT 05819

E: s.merrow@nvrh.org
P: 802-748-7419
F: 802-748-7527

4/24/13
B. Dineen

POLICY AND PROCEDURE FOR ACCESSIBILITY OF PATIENT'S MEDICAL RECORDS

Policy: A medical record shall be maintained for every individual who has any type of encounter at Northeastern VT Regional Hospital and hospital owed physician practices. All records shall be accessible for people who are authorized to view or want printed or digital copies of such records. The Medical Records Department bears the responsibility for the oversight of accessibility of all records.

The contents of our records are maintained either in paper or electronic format. Meditech is our main storage system for the EMR. OBS/Nursery uses a software program call Centricity to maintain most of the EMR for obstetrics and nursery patients, although certain parts of the record are in Meditech. Physician owned practices EMR are accessible through a system known as LSS.

All paper records for hospital encounters are stored in the Medical Records Department in assigned Unit # for each individual. Paper records for the practices are stored in Unit records also at the premise of each practice.

As of March 1, 2013 NVRH converted our software system to Meditech 6.0. The EMR in Meditech 6.0 consists of anything new since 3/1/2013. Anything new since 3/1/2013 scanned can be found in a product called Hyland. Anything before 3/1/2013 can be found in Hyland or PCI (through 6.0 PCI Link). The only records not stored on Meditech are the ones that Centricity houses, and the physician practice EMR. The practice office EMR, LSS, has anything new since 3/1/2013 along with office notes before 3/1/2013, and anything else before 3/1/2013 is in PCI.

The records from OBS/Nursery are stored in Centricity for 120 days. After that the records are downloaded to a CD. There will be three copies of the CD made, one for OBS/Manager's Office, one for Medical Records and one for IT which will be stored offsite. See attached procedure for restoring records from GE Centricity.

All records generated for NVRH and/or NVRH owned practices shall be accessible and systematically organized under the direction Medical Records.

Meditech 6.0:

EMR – Anything new since 3/1

Hyland – Anything scanned since 3/1

Anything older than 3/1 can be found in Hyland or PCI (through 6.0 PCI Link)

The LSS record:

LSS EMR – Anything new since 3/1

LSS EMR Clinic Notes – Everything

Anything before 3/1 is in PCI

Date of Policy: 4/12/2013

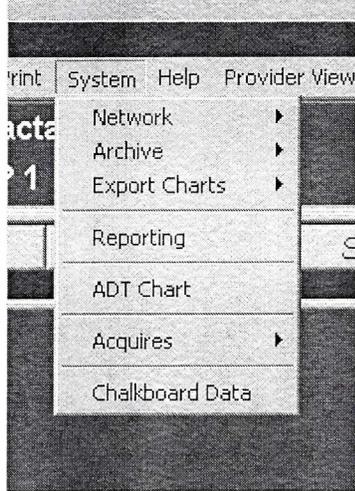
Approved by: Susan E. Merrow, RHIT, CPC
Manager of Medical Records

4-24-13
B Han/LL

Restoring Records from GE Centricity

I. TO RESTORE if patient has not been archived (< 120 days)

1. Open regular system- not designer – look on top banner- find “System”- drop down menu> “Archive”> “Store”. You cannot perform this task on a remote station; you need a fat client.



2. Screen will open- check the box on top that has patient name/# in it- type in first 3-4 letters of the name and chart should open. Select which unit you want to restore the record in (can be in Restored unit or any other unit you select) and then select “RESTORE” and the record will be available in this unit.

Restore Patient

Search for patients who meet all criteria

Patient Id

 Patient Name

 CD-ROM
 Hard Drive
 Date Archived

Restore to Unit

- General hold
- Lactation
- NUR
- OBS
- Restored
- Train
- Training Undelivered
- Undelivered

Select the patient to be restored

Restore options: Hard Drive CD-ROM

Patient Id	Patient Name	CD-ROM	Hard Drive	Date Archived	File Name	File :

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After 120 days, the records are sent to a CD. IF the chart has been archived to CD already, need to get that CD. Three copies will be saved- one in OB's manager's office one in IT which is stored offsite, and one for Medical Records.

II. To RESTORE from a CD-

NOTE the number that is associated with the patient name to tell you WHAT CD to find the patient-

- Example: So for TEST PATIENT- QS.136201201
 - QS= name of system
 - 136= is the day of the year it was archived
 - 2012=the year archived
 - 01=the volume number of the year- so # 1 volume of 2012

NOTE: MUST enter this number on the CD as it will not label it for you

Open the system and follow step 1 above.

1. Insert the CD
2. The patient will be found on the CD
3. Click "Restore"
4. The patient will be restored> in the Restored Unit unless you have selected another unit.
5. As above the restored record will now have an added "RO" @ the end of their MRN to indicate the record has been restored.

Restored.Hold			
Restored.Hold	TEST PATIENT	M064702-RO	THOMAS, GA... 1986-09-02

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